

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>000246</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/11/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>WEST BEND NURSING AND REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4600 W WASHINGTON AVE SOUTH BEND, IN 46619</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 000	<p><b>INITIAL COMMENTS</b></p> <p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 10/11/12</p> <p>Facility Number: 000246 Provider Number: 155355 AIM Number: 100275420</p> <p>Surveyor: Robert Sutton, Life Safety Code Specialist Trainee</p> <p>At this Quality Assurance Walk-thru survey, West Bend Nursing and Rehabilitation was found in compliance with 410 IAC 16.2-3.1-19(ff).</p> <p>This facility consists of two connected buildings: one built in 1976, is a two story building and the original construction built in 1967 is a one story building with a partial basement. Both Buildings are determined to be of Type II (222) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, and areas open to the corridors with battery operated smoke detectors in the resident rooms. The facility has a capacity of 177 and had a census of 89 at the time of this visit.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/15/12.</p>	K 000		

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 2

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